No. 00-1471

IN THE

Supreme Court of the United States

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., *et al.*,
Petitioners,

v.

JANIE MILLER, COMMISSIONER OF THE KENTUCKY DEPARTMENT OF INSURANCE,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF OF THE COUNCIL OF STATE GOVERNMENTS, NATIONAL CONFERENCE OF STATE LEGISLATURES, NATIONAL GOVERNORS ASSOCIATION, NATIONAL LEAGUE OF CITIES, U.S. CONFERENCE OF MAYORS, INTERNATIONAL CITY/COUNTY MANAGEMENT ASSOCIATION, AND NATIONAL ASSOCIATION OF COUNTIES AS *AMICI CURIAE* SUPPORTING RESPONDENT

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QUESTION PRESENTED

Whether Kentucky's Any Willing Provider statutes are saved from preemption by ERISA's saving clause because they are state laws that regulate insurance.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
TABLE OF AUTHORITIES	v
INTEREST OF THE *AMICI CURIAE*	1
SUMMARY OF ARGUMENT	2
ARGUMENT	6
ANY WILLING PROVIDER LAWS ARE STATE LAWS REGULATING INSURANCE THAT ARE SAVED FROM PREEMPTION BY ERISA'S SAVING CLAUSE	6
A. Kentucky's AWP Laws Regulate Insurance As A Matter Of Common Sense	8
1. Kentucky's AWP Laws Are Specifically Directed At Insurance Industry Entities And Practices	8
2. Kentucky's AWP Laws Are Enforced By The State Insurance Department	11
3. Kentucky's AWP Laws Are Grounded In Policy Concerns Specific To The Insurance Industry	13
B. Consideration Of The McCarran-Ferguson Factors Reinforces The Conclusion That Kentucky's AWP Laws Regulate Insurance	14
1. This Court Reads The McCarran-Ferguson Factors Broadly To Protect The States' Paramount Role In Regulating Insurance	14

TABLE OF CONTENTS—Continued

	Page
2. Kentucky's AWP Laws Satisfy All Three McCarran-Ferguson Factors	17
C. ERISA Preemption of Kentucky's AWP Laws Would Deprive States Of The Ability To Regulate HMO Insurance Practices And Would Create A Regulatory Void	26
CONCLUSION	28

TABLE OF AUTHORITIES

Cases	Page
FMC v. Seatrain Lines, Inc., 411 U.S. 726 (1973)	15
Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979)	*passim*
Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985)	*passim*
New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995)	26
Northwestern Nat'l Life Ins. Co. v. Riggs, 203 U.S. 243 (1906)	6
Pacific Gas & Elec. Co. v. State Energy Res. Conserv. & Dev. Comm'n, 461 U.S. 190 (1983)	26
Pegram v. Herdrich, 530 U.S. 211 (2000)	11, 19, 26-27
Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987)	2, 7, 14
Rice v. Santa Fe Elevator Corp., 330 U.S. 218 (1947)	26
Rush Prudential HMO, Inc. v. Moran, 122 S. Ct. 2151 (2002)	*passim*
SEC v. National Securities, Inc., 393 U.S. 453 (1969)	10, 12, 15, 25
SEC v. Variable Annuity Life Ins. Co., 359 U.S. 65 (1959)	6
Stuart Circle Hosp. Corp. v. Aetna Health Mgmt., 995 F.2d 500 (4th Cir.), *cert. denied*, 510 U.S. 1003-04 (1993)	18, 20
Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119 (1982)	*passim*
UNUM Life Ins. Co. of America v. Ward, 526 U.S. 358 (1999)	*passim*

TABLE OF AUTHORITIES—Continued

	Page
U.S. Dep't of Treasury v. Fabe, 508 U.S. 491 (1993)	*passim*

Statutes

Ala. Code § 27-45-3 (Supp. 2002)	27
Ala. Code § 27-45-7 (Supp. 2002)	11
Ark. Code Ann. § 23-99-202 (Michie 1999)	13
Ark. Code Ann. § 23-99-204(a)(3) (Michie 1999)	27
Conn. Gen. Stat. Ann. § 38a-471(f) (2000)	27
Del. Code Ann. tit. 18, § 7302(a) (1999)	13
Del. Code Ann. tit. 18, § 7303 (1999)	27
Ga. Code Ann. § 33-20-16 (2000)	27
Ga. Code Ann. § 33-20-26 (2000)	11-12
Idaho Code § 41-3901 *et seq.* (Michie 1998 & Supp. 2002)	13
Idaho Code § 41-3902 (Michie 1998)	13
Idaho Code § 41-3927(1) (Michie 1998)	27
215 Ill. Comp. Stat. 134/72(a) (2000)	27
215 Ill. Comp. Stat. 5/370h (2000)	27
Ind. Code Ann. § 27-8-11-3(c) (Michie 1999)	27
Ky. Rev. Stat. Ann. § 304.3-200 (Michie 1996)	3, 11
Ky. Rev. Stat. Ann. § 304.3-200(1)(c) (Michie 1996)	12, 13
Ky. Rev. Stat. Ann. § 304.17A-005(23) (Michie Supp. 2001)	8
La. Rev. Stat. Ann. § 22:1214(15)(a) (West 1995)	27
Mass. Gen. Laws Ann. ch. 176D, § 3B (West 1998)	12, 27
Miss. Code Ann. § 83-9-6 (1999)	27
Miss. Code Ann. § 83-9-6(7) (1999)	12
Miss. Code Ann. § 83-41-203 (1999)	28

TABLE OF AUTHORITIES—Continued

	Page
N.C. Gen. Stat. § 58-51-37 (2001)	27
N.C. Gen. Stat. § 58-51-37(i) (2001)	12
N.D. Cent. Code § 26.1-36-12.2 (1995)	27
N.D. Cent. Code § 26.1-36-12.2(5) (1995)	12
N.H. Rev. Stat. Ann. § 420-B:12(V.) (1998)	27
N.J. Stat. Ann. § 26:2J-4.7 (West 1996)	27
Okla. Stat. tit. 36, § 3634 (1999)	28
S.C. Code Ann. § 38-71-147 (Law. Co-op. 2002)	27
S.D. Codified Laws § 58-18-37 (Michie 2000)	27
Tenn. Code Ann. § 56-7-2359 (2000)	27
Tex. Ins. Code Ann. § 21.52B (Vernon Supp. 2002)	27
15 U.S.C. §§ 1011 *et seq*	6
15 U.S.C. § 1011	6
15 U.S.C. § 1012(b)	*passim*
29 U.S.C. § 1144(b)(2)(A)	*passim*
Utah Code Ann. § 31A-22-617(4)(b) (2001)	12
Wash. Rev. Code § 48.44.020(2)(f) (1999)	12
Wyo. Stat. Ann. § 26-22-503 (Michie 2001)	27

Other Authorities

Rea Blakey, *Pharmacies Jeopardizing Patient Privacy* (June 12, 2002), *at* http://www.cnn.com/2002/HEALTH/06/12/pharmaceutical.privacy/index.html	22-23
James W. Childs, Jr., Comment, *You May Be Willing, But Are You Able?: A Critical Analysis of "Any Willing Provider" Legislation*, 27 Cumb. L. Rev. 199 (1996)	19
Julia Field Costich & Mike Helton, *The Kentucky Health Reform Act*, 22 N. Ky. L. Rev. 381 (1995)	14

TABLE OF AUTHORITIES—Continued

Page

Sarah Godfrey, *Crummy Variety Store: With 50 Outlets in the District, CVS has a near monopoly on drugs, cough syrup, hair spray—and customer dissatisfaction*, Washington City Paper, March 1-7, 2002, *available at* http://www.washingtoncitypaper.com/archives/cover/2002/print_cover0301.html..... 22

Dianne McCarthy, Note, *Narrowing Provider Choice: Any Willing Provider Laws After* New York Blue Cross v. Travelers, 23 Am. J.L. & Med. 97 (1997)..... 9, 21

Note, *Health Care Law—HMO Regulation—Arkansas Requires HMOs to Accept Any Provider Willing to Join Their Networks*, 109 Harv. L. Rev. 2122 (1996)..... 18

INTEREST OF THE *AMICI CURIAE*

Amici are organizations whose members include state, county, and municipal governments and officials throughout the United States.[1] *Amici* have a compelling interest in preserving the States' longstanding power to regulate insurance and in ensuring that ERISA is read in a manner consistent with that authority.

For 150 years the regulation of insurance has been the responsibility of the States. Congress expressly preserved this exercise of the States' historic police powers in the McCarran-Ferguson Act and reaffirmed it thirty years later in ERISA's saving clause. Any Willing Provider laws such as the Kentucky statutes at issue in this case and those adopted in roughly twenty-five other States are classic instances of state insurance regulation. Their purpose is to redress the imbalance that exists in those HMOs that limit entry into provider networks, thereby unduly restricting provider choice on the part of insured persons.

Petitioners urge this Court to disregard the well-settled legal principles—applied to HMOs just last term in *Rush Prudential HMO, Inc. v. Moran*, 122 S.Ct. 2151 (2002)—that give an appropriately broad reading to the scope of ERISA's saving clause for state laws that regulate insurance. *Amici* respectfully submit that if this Court were to accept petitioners' constricted reading of ERISA's saving clause, state insurance regulation would be severely curtailed and a deleterious regulatory void would result because the Federal Government has consistently looked to the States as the primary regulators of insurance.

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[1] The parties have consented to the filing of *amicus* briefs in this case by filing blanket consents with the Clerk of the Court. This brief was not authored in whole or in part by counsel for a party, and no person or entity, other than *amici* or their members, has made a monetary contribution to the preparation or submission of this brief.

Because the issue presented critically affects the States' ability to exercise core components of their historic police powers, *amici* submit this brief to assist the Court in the resolution of this case

SUMMARY OF ARGUMENT

As this Court has long recognized, the authority to regulate insurance is one of the States' historic police powers. Congress consistently defers to state regulation in this area and expressly authorized state regulation of insurance when it enacted the McCarran-Ferguson Act and, thirty years later, ERISA's saving clause.

ERISA expressly saves from federal preemption "any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(A). In applying the saving clause, the Court uses a two-part test. First, the Court asks whether, as a matter of common sense, the law is "specifically directed toward [the insurance] industry." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987). Second, the Court "test[s] the results of the common-sense enquiry by employing the three factors used to point to insurance laws spared from federal preemption under the McCarran-Ferguson Act." *Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151, 2159 (2002) (citation omitted).

A. Kentucky's AWP laws regulate insurance as a matter of common sense because they home in on the insurance industry—they are specifically and exclusively targeted at entities engaged in the business of insurance. Furthermore, they affect the nature of the contract between the insurer and the insured by regulating an insurer's ability to limit the size of the provider network made available to the insured. While AWP laws may also affect the relationship between insurers and providers, they are ultimately aimed at increasing an insured's choice of providers.

Moreover, Kentucky's AWP laws are grounded in policy concerns related to the insurer-insured relationship. Indeed, Kentucky's AWP laws were enacted precisely in order to regulate the insurer-insured relationship and "increase benefits to the insureds by giving them greater freedom to choose health care providers under the plans." Pet. App. 30a. Finally, Kentucky's AWP laws regulate insurance as a matter of common sense because they are enforced by Kentucky's insurance commissioner, who is granted authority to revoke an insurer's certificate of operation if the insurer refuses to comply with the AWP provisions. *See* Ky. Rev. Stat. Ann. § 304.3-200 (Michie 1996).

B. The common-sense conclusion that Kentucky's AWP laws regulate insurance is validated by all three of the McCarran-Ferguson factors.

The first factor asks whether a law "targets practices or provisions that 'ha[ve] the effect of transferring or spreading a policyholder's risk.'" *Rush Prudential*, 122 S. Ct at 2163 (citation omitted). Kentucky's AWP statutes satisfy this factor in two ways. First, by requiring insurers to widen provider pools, the statutes reduce the risk that an insured will have to pay higher out-of-pocket costs because a health care provider of choice is not within the HMO's network. Thus, the Kentucky AWP statutes decrease the insureds' risk of paying higher out-of-pocket costs to receive treatment from doctors of their choice, rather than of the HMO's choosing. Second, AWP laws may also reapportion risk insofar as they may require insureds to bear the additional cost of greater provider choice through higher premiums.

The Kentucky AWP statutes also satisfy the second McCarran-Ferguson factor, which asks whether the law affects an integral part of the policy relationship between the insurer and the insured. By requiring open networks, Kentucky's AWP laws make it more likely that insureds will be able to choose their preferred doctors. As noted by the court

below, this "removal of a restriction on availability of providers is . . . a benefit conferred on the insureds. It effectively changes the terms of the policy, admittedly not in terms of covered medical condition but in terms of covered treatment by health care providers." Pet. App. 31a-32a. Moreover, even if insureds' first-choice providers are not in the network, a larger network nonetheless enhances their range of choices. By legislatively amending the terms of insurance contracts to confer greater provider choice on insureds, Kentucky's AWP statutes make this choice an integral part of the policy relationship between insurer and insured.

Petitioners argue that provider choice is no more significant here than in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), where the Court concluded that a limited network of pharmacists was not an integral part of the policy relationship and that policyholders were "basically unconcerned" with pharmacy choice. *Id.* at 214. This observation, made by the Court in the context of a determination of whether an insurer was entitled to an exemption from federal antitrust laws, is not relevant here.

First, the Kentucky AWP laws reflect a state legislative determination that provider choice is important to insureds. In contrast, the policyholders in *Royal Drug*, by accepting the terms of the policy, did not demonstrate a concern about choice. Second, by expanding provider networks, Kentucky's AWP laws make choice an integral part of the policy. Finally, and most importantly, petitioners' *Royal Drug* argument fails to account for the fact that state laws regulating insurance are not evaluated under ERISA's saving clause in the same way as is an insurer's right to an antitrust exemption under the McCarran-Ferguson Act. *See U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 504-06 (1993). Thus, preservation of Kentucky's AWP laws from preemption by ERISA is entirely consistent with the outcome

of *Royal Drug*—both ultimately favor regulation of the insurance industry, by the States as a general matter and by the Federal Government as to antitrust.

Kentucky's AWP statutes also satisfy the third McCarran-Ferguson factor—whether the law "targets practices or provisions that '. . . [are] limited to entities within the insurance industry.'" *Rush Prudential*, 122 S. Ct. at 2163 (citation omitted). AWP laws target insurance industry cost-cutting practices that limit alternatives for treatment available to insureds. These laws have no application outside the insurance industry. In this regard, petitioners' argument that the target of Kentucky's AWP laws is the provider-insurer contract ignores the meaning of the third McCarran-Ferguson factor, which asks whether the law *targets* practices or provisions limited to insurance industry entities. While these laws may have *consequences* that affect health care providers, this does not alter the fact that the target of the Kentucky AWP laws is practices of health care insurers and the provider networks they offer to insureds.

C. Reversal of the judgment below could call into question the validity of numerous state laws, as approximately twenty-five States have enacted some form of AWP statute. Preemption under ERISA would also be inconsistent with the presumption that federal statutes should not be construed to create a regulatory void by preempting state regulation in areas where there is no federal regulation. The substantive policy implications of preemption are even more pronounced in the context of insurance law, an area where Congress has consistently deferred to state regulation.

Because ERISA does not regulate either HMOs' insurance practices or their health care practices, a deleterious regulatory void would be the inevitable result of a reversal of the judgment below. Given the manifest importance of state insurance regulation and state regulation of insurers' health care practices, the judgment below should be affirmed.

ARGUMENT

ANY WILLING PROVIDER LAWS ARE STATE LAWS REGULATING INSURANCE THAT ARE SAVED FROM PREEMPTION BY ERISA'S SAVING CLAUSE.

As this Court has long recognized, the regulation of insurance is a historic function of the States. *See, e.g.*, *SEC v. Variable Annuity Life Ins. Co.*, 359 U.S. 65, 68 (1959) ("When the States speak in the field of 'insurance,' they speak with the authority of a long tradition."); *see also Northwestern Nat'l Life Ins. Co. v. Riggs*, 203 U.S. 243, 254 (1906). In enacting the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.*, Congress declared as national policy that "the continued regulation and taxation by the several States of the business of insurance is in the public interest." *Id.* § 1011. Section 2(b) of McCarran-Ferguson expressly states that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance." *Id.* § 1012(b).

This national policy was reaffirmed in ERISA, whose saving clause, 29 U.S.C. § 1144(b)(2)(A), exempts from preemption "any law of any State which regulates insurance." Indeed, ERISA's "saving clause and the McCarran-Ferguson Act serve the same federal policy and utilize similar language to define what is left to the States." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744 n.21 (1985). As the Court has held, "[t]he ERISA saving clause, with its similarly worded protection of 'any law of any State which regulates insurance,' appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States." *Id.* While ERISA's saving clause, like the McCarran-Ferguson Act, necessarily results in variations in insurance regulation from State to State, "[s]uch

disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation." *Rush Prudential HMO, Inc. v. Moran*, 122 S. Ct. 2151, 2167 (2002) (citing *Metro. Life*, 471 U.S. at 747).

The two-step analysis for determining whether a state law regulates insurance within the meaning of ERISA's saving clause is well established. The Court "start[s] with a 'common-sense view of the matter,' under which 'a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry.'" *Rush Prudential*, 122 S. Ct. at 2159 (quoting *Metro. Life*, 471 U.S. at 740; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987)). A law which "regulates the terms of . . . insurance contracts" is also "a law 'which regulates insurance'" under the common-sense test. *Metro. Life*, 471 U.S. at 740 (quoting 29 U.S.C. § 1144(b)(2)(A)).

Second, this Court "test[s] the results of the common-sense enquiry by employing the three factors used to point to insurance laws spared from federal preemption under the McCarran-Ferguson Act." *Rush Prudential*, 122 S. Ct. at 2159 (citation omitted). These are: (1) whether the practice in question has the effect of transferring or spreading an insured's risk; (2) whether the law regulates an integral part of the relationship between the insurer and the insured; and (3) whether the law applies only to entities within the insurance industry. *Id.* at 2163 (citing *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)). "Because the factors are guideposts, a state law is not required to satisfy all three McCarran-Ferguson criteria to survive preemption. . . ." *Id.* (citing *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 373 (1999)).

Kentucky's AWP laws regulate insurance as a matter of common sense, a conclusion that is validated by all three of the McCarran-Ferguson factors. The judgment of the court of appeals should therefore be affirmed.

A. Kentucky's AWP Laws Regulate Insurance As A Matter Of Common Sense.

In *Rush Prudential*, this Court expressly held that HMOs are "insurers" under ERISA's saving clause.[2] *See* 122 S. Ct. at 2160 ("an HMO . . . provides health care, and it does so as an insurer"). The only question that remains is whether Kentucky's AWP laws regulate HMOs acting as insurers.

1. *Kentucky's AWP Laws Are Specifically Directed At Insurance Industry Entities And Practices.*

Kentucky's AWP laws regulate insurance as a matter of common sense because they are specifically directed at the insurance practices and policies of entities within the insurance industry. This is clear from the plain language of Kentucky's AWP statutes. They define health "insurer" as "any insurance company; *health maintenance organization*; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health services corporation authorized to transact health insurance business in Kentucky." Ky. Rev. Stat. Ann. § 304.17A-005(23) (Michie Supp. 2001) (emphasis added).

Furthermore, Kentucky's AWP laws are targeted exclusively at entities within the insurance industry, another

[2] HMOs are only one form of managed care entity. "The term 'Managed Care Organization' is used more broadly to refer to any number of systems combining health care delivery with financing." *Rush Prudential*, 122 S. Ct. at 2157 n.1 (citation omitted). Indeed, this Court has recognized that "'an observer may be hard pressed to uncover the differences among products that bill themselves as HMOs, [preferred provider organizations], or managed care overlays to health insurance.'" *Id.* at 2161 (citation omitted). Although AWP laws frequently encompass managed care entities other than HMOs, *amici* use the term "HMO" in this brief because that is the term used by petitioners and the court below.

consideration highly germane to the common-sense test. *See Rush Prudential*, 122 S. Ct. at 2164 (holding that state law satisfied the common-sense test in part because it "does not apply to entities outside the insurance industry (although it does not, of course, apply to all entities within it)"). *Accord UNUM*, 526 U.S. at 368 (fact that California's notice-prejudice rule "is directed specifically at the insurance industry and is applicable only to insurance contracts" was significant in this Court's determination that the rule "satis-[fied] the common-sense view as a regulation that homes in on the insurance industry").

Not only do Kentucky's AWP laws apply exclusively to insurance companies, they affect the nature of the insurance being provided through the insurance contract. This further confirms that they regulate insurance as a matter of common sense. *See Metro. Life*, 471 U.S. at 740-41 (fact that state law regulated the substantive terms of insurance contracts established that the law satisfied common-sense test). AWP laws affect the nature of the insurer's promise by regulating the insurer's ability to limit the size of the network of providers available to the insured.[3] *See* Pet. Br. 4 ("The purpose and effect of these AWP laws is to require petitioners and other HMOs to throw open their closed provider networks to any provider in the geographic area willing to abide by the terms of their network contracts."). This "effect of eliminating an insurer's autonomy to guarantee terms congenial to its own

[3] It is ironic that petitioners contend that AWP laws are not integral to the relationship between the insurer and the insured, Pet. Br. 34, given that some HMOs use the size of the network as a selling point to potential customers, claiming "not just that they have a large panel but also that they have your current provider on that panel." *See* Dianne McCarthy, Note, *Narrowing Provider Choice: Any Willing Provider Laws After* New York Blue Cross v. Travelers, 23 Am. J.L. & Med. 97, 109 (1997) (quoting an HMO advertisement claiming: "'I did not choose them because they had 11,000 doctors, I chose them because they had mine'").

interests is the stuff of garden variety insurance regulation through the imposition of standard policy terms." *Rush Prudential*, 122 S. Ct. at 2171 (citing *Metro. Life*, 471 U.S. at 742).

Petitioners contend that Kentucky's AWP laws do not regulate insurance as a matter of common sense because they regulate insurers' contracts with providers, not insureds. Pet. Br. 35-36. This argument is without merit. Although some AWP laws may use the provider-insurer contract as the mechanism of regulation, the ultimate consequence is that insureds are likely to have more provider choices than they would in the absence of regulation. While AWP laws may affect the relationship between insurers and providers, they are laws that fundamentally change the relationship between insurers and insureds. *See Metro. Life*, 471 U.S. at 744 ("'Statutes aimed at protecting or regulating [the insurer-policyholder] relationship, *directly or indirectly*, are laws regulating "the business of insurance."'") (quoting *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969)) (emphasis added).

Moreover, in *Rush Prudential* this Court held that ERISA's saving clause does not require that a state law be hermetically sealed around the insurance aspects of health care "as long as providing insurance fairly accounts for the application of state law." 122 S. Ct. at 2160. Indeed, an effect on the insurer-provider relationship does not make an AWP law any less a law "which regulates insurance," 29 U.S.C. § 1144(b)(2)(A), because "[n]othing in [ERISA's] saving clause requires an either-or choice between health care and insurance in deciding a preemption question." *Rush Prudential*, 122 S. Ct. at 2160.

It is thus unpersuasive to argue that AWP laws are pre-empted because they are health care laws rather than insurance laws. *See* Br. *Am. Cur.* Society for Human Res. Mgmt. 19-21. *Rush Prudential* squarely held that an HMO

"both . . . provides health care and . . . does so as an insurer," and is thus subject to state insurance regulation. 122 S. Ct. at 2160. The inherent health care implications of Kentucky's AWP laws therefore do not warrant a finding of ERISA preemption.

Moreover, even if they are viewed as health care regulations as well as insurance regulations, AWP laws still fall within the ambit of state authority, for "'[i]n the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose.'" *Id.* at 2171 (quoting *Pegram v. Herdrich*, 530 U.S. 211, 236 (2000)). In this regard, "it helps to go back to where we started and recall the ways States regulate insurance in looking out for the welfare of their citizens." *Id.* at 2170. States with AWP laws "ha[ve] chosen to regulate insurance as one way to regulate the practice of medicine [which this Court has] previously held to be permissible under ERISA." *Id.* at 2170-71 (citing *Metro. Life*, 471 U.S. at 741). Furthermore, this Court has noted that state insurance regulation that is tied to the practice of medicine "is probably inseparable from enforcing the quintessentially state-law standards of reasonable medical care," *id.* at 2171, which supports the conclusion that ERISA's saving clause applies.

2. *Kentucky's AWP Laws Are Enforced By The State Insurance Department.*

The fact that Kentucky's Department of Insurance enforces the State's AWP laws, *see* Ky. Rev. Stat. Ann. § 304.3-200 (Michie 1996), as do insurance departments in many other States,[4] confirms the conclusion that AWP laws regulate

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[4] *See, e.g.*, Ala. Code § 27-45-7 (Supp. 2002) ("The commissioner of insurance shall not approve for sale in this state any health insurance policy . . . providing for pharmaceutical services, including without limitation, prescription drugs, which does not conform to the provisions of this article. . . ."); Ga. Code Ann. § 33-20-26 (2000) ("The Commissioner

insurance. "'The relationship between the insurer and insured, . . . its interpretation, *and enforcement*—these were the core of the "business of insurance."'" *Metro. Life*, 471 U.S. at 744 (quoting *SEC v. National Securities*, 393 U.S. at 460) (emphasis added); *see also Rush Prudential*, 122 S. Ct. at 2161 n.5 (state classification of a statute as an insurance law is "relevant to the enquiry" of whether the statute regulates insurance).

Contrary to the contention that Kentucky's AWP laws were placed in the insurance code merely as a ruse to evade ERISA preemption, *see* Br. *Am. Cur.* Community Health Partners 12-13, Kentucky's legislature granted the state insurance commissioner power to revoke an insurer's certificate of authority if an insurer refuses to comply with the AWP provisions. *See* Ky. Rev. Stat. Ann. § 304.3-200(1)(c) (Michie 1996) ("The commissioner may . . . revoke an insurer's certificate of authority if he finds . . . that the insurer has . . . [w]illfully violated any provision of this code. . . .").

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shall have the authority to take appropriate actions authorized by this title for the protection of a health care corporation's subscribers and the public health and welfare. . . ."); Mass. Gen. Laws Ann. ch. 176D, § 3B (West 1998) ("The commissioner of the division of insurance shall have authority to enforce the provisions of this section."); Miss. Code Ann. § 83-9-6(7) (1999) ("The Commissioner of Insurance shall not approve any health benefit plan providing pharmaceutical services which does not conform to this section."); N.C. Gen. Stat. § 58-51-37(i) (2^01) ("The Commissioner shall not approve any health benefit plan providing pharmaceutical services which does not conform to this section."); N.D. Cent. Code § 26.1-36-12.2(5) (1995) ("The commissioner of insurance shall enforce the provisions of this section."); Utah Code Ann. § 31A-22-617(4)(b) (2001) ("The commissioner in consultation with the executive director of the Department of Health may designate qualified persons to perform an audit of the quality assurance program."); Wash. Rev. Code § 48.44.020(2)(f) (1999) ("The commissioner may on examination . . . disapprove any contract form . . . [i]f it violates any provision of this chapter[.]").

This revocation authority is identical to that available to the Commissioner to enforce the other provisions of the Kentucky Insurance Code. *See id.*

3. *Kentucky's AWP Laws Are Grounded In Policy Concerns Specific To The Insurance Industry.*

Finally, Kentucky's AWP laws are "grounded in policy concerns specific to the insurance industry," a consideration that was "key to [this Court's] decision" in *UNUM*. *See* 526 U.S. at 372. Kentucky's AWP laws were enacted to regulate the relationship between insurers and insureds by requiring HMOs to open their networks to additional providers, thereby "increas[ing] benefits to the insureds by giving them greater freedom to choose health care providers under the plans."[5] Pet. App. 30a; *see also, e.g.*, Ark. Code. Ann. § 23-99-202 (Michie 1999) (General Assembly finds that "patients should be given the opportunity to see the health care provider of their choice. In order to assure the citizens of the State of Arkansas the right to choose the provider of their choice, it is the intent of the General Assembly to provide the opportunity of providers to participate in health benefit plans."). Indeed, the Kentucky legislature enacted its original AWP statutes as

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[5] Other States have expressed similar legislative purposes when enacting AWP statutes. For example, the Idaho General Assembly enacted an AWP law as part of the State's "Managed Care Reform Act," Idaho Code § 41-3901 *et seq.* (Michie 1998 & Supp. 2002). In providing insureds with broad access to all willing providers, the Idaho legislature declared that it "wishe[d] to eliminate legal barriers to the establishment of managed care plans which provide readily available, accessible and quality health care to their members." *Id.* at § 41-3902. Similar legislative findings have been made in support of pharmacy AWP laws. *See, e.g.*, Del. Code. Ann. tit. 18, § 7302(a) (1999) ("pharmaceutical services and prescription drugs are an essential service to the people of this State and . . . the broadest possible access to such services should be mandated").

part of a major health insurance reform measure. *See* Julia Field Costich & Mike Helton, *The Kentucky Health Reform Act*, 22 N. Ky. L. Rev. 381, 391 (1995).

From the foregoing it is clear as a matter of common sense that Kentucky's AWP laws regulate insurance under ERISA's saving clause.

B. Consideration Of The McCarran-Ferguson Factors Reinforces The Conclusion That Kentucky's AWP Laws Regulate Insurance.

The common-sense conclusion that Kentucky's AWP laws are not preempted by ERISA is confirmed by "the three factors used to point to insurance laws spared from federal preemption under the McCarran-Ferguson Act." *Rush Prudential*, 122 S. Ct. at 2159. Moreover, while "a state law is not required to satisfy all three McCarran-Ferguson criteria to survive preemption," *id.* at 2163 (citing *UNUM*, 526 U.S. at 373), Kentucky's AWP laws satisfy all three.[6]

1. *This Court Reads The McCarran-Ferguson Factors Broadly To Protect The States' Paramount Role In Regulating Insurance.*

At the outset, *amici* note that petitioners, in addressing the McCarran-Ferguson factors, fail to recognize that the Court applies them in two distinct contexts. The McCarran-Ferguson factors were first identified in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). *See Pireno*, 458 U.S. at 126-30 (citing and quoting *Royal Drug*, 440 U.S. at 209-31). *Royal Drug* involved the application of the second clause of § 2(b) of the McCarran-Ferguson Act, 15

[6] This Court has variously described the McCarran-Ferguson factors as "guideposts," *Rush Prudential*, 122 S. Ct. at 2163, "considerations," *UNUM*, 526 U.S. at 373 (quoting *Pilot Life*, 481 U.S. at 49), and "criteria," *id.* (quoting *Pireno*, 458 U.S. at 129). This further indicates their flexible role in saving clause analysis.

U.S.C. § 1012(b), which creates an *exemption* from the federal antitrust laws for the "business of insurance." *See* 440 U.S. at 210. The *Royal Drug* Court emphasized "that exemptions from the antitrust laws are to be narrowly construed." *Id.* at 231; *accord Pireno*, 458 U.S. at 126 ("our precedents consistently hold that exemptions from the anti-trust laws must be construed narrowly") (citing *FMC v. Seatrain Lines, Inc.*, 411 U.S. 726, 733 (1973)). The Court accordingly developed a criteria-based analysis consistent with fulfilling the Act's "*secondary* purpose of . . . giv[ing] insurance companies only a limited exemption from the antitrust laws." *Royal Drug*, 440 U.S. at 218 n.18.

Analysis under the second clause of § 2(b), the antitrust exemption, is not pertinent here. Rather, the first clause of § 2(b) of McCarran-Ferguson, which implements Congress' "*primary* purpose of . . . preserv[ing] state regulation of the activities of insurance companies," *id.*, is controlling. This saving clause is given a far broader reading than the antitrust exemption in the second clause. *See U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 504-06 (1993); *see also id.* at 501 ("'Statutes aimed at protecting or regulating this relationship [between insurer and insured], *directly or indirectly*, are laws regulating the 'business of insurance,' within the meaning of the phrase.") (emphasis added) (quoting *SEC v. National Securities*, 393 U.S. at 460).

This Court has noted that "[t]he ERISA saving clause, with its similarly worded protection of 'any law of any State which regulates insurance,' appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States" in the first clause of § 1012(b). *Metro. Life*, 471 U.S. at 744 n.21. ERISA's saving provision, like the first clause of § 2(b) of McCarran-Ferguson, saves from preemption "any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(A). ERISA's saving clause is thus at least as protective of state insurance laws as the first clause of § 2(b) of McCarran-

Ferguson. Indeed, the statutes have a common goal: to preserve "the States[']broad regulatory authority over the business of insurance." *Fabe*, 508 U.S. at 505; *see also Metro. Life*, 471 U.S. at 744 n.21. This conclusion follows from the textual similarity of ERISA's saving clause to the first clause of § 2(b) of the McCarran-Ferguson Act,[7] the identical purpose of the two provisions, and from this Court's use of the McCarran-Ferguson factors to "test the results of the common-sense enquiry" that is the first step in ERISA saving clause analysis. *Rush Prudential*, 122 S. Ct. at 2159.

Moreover, the Court has "indicated that the McCarran-Ferguson factors are considerations [to be] weighed in determining whether a state law regulates insurance, and that none of these criteria is necessarily determinative in itself." *UNUM*, 526 U.S. at 373 (internal citations and quotation marks omitted); *see also Rush Prudential*, 122 S. Ct. at 2163 ("Because the factors are guideposts, a state law is not required to satisfy all three McCarran-Ferguson criteria to survive preemption. . . .") (citation omitted). This flexible approach is informed by the fact that when the McCarran-Ferguson criteria are applied in ERISA saving clause analysis the interest of the State in regulating the insurance industry must also be taken into account. For this reason, these factors are read more flexibly where these saving provisions are at

[7] *Compare* 29 U.S.C. § 1144(b)(2)(A) (saving from preemption "any law of any State which regulates insurance") *and* 15 U.S.C. § 1012(b) cl. 1 (saving "any law enacted by any State for the purpose of regulating the business of insurance") *with* 15 U.S.C. § 1012(b) cl. 2 (providing that federal antitrust laws "shall be applicable to the business of insurance to the extent that such business is not regulated by State law"). Thus both this Court's holding in *Metropolitan Life* and the text of these statutes directly contradict petitioners' suggestion that ERISA's clause saving state laws that regulate insurance has a "close linguistic similarity" to McCarran-Ferguson's business of insurance antitrust exemption. *See* Pet. Br. 37.

issue and thus are also read more broadly than McCarran-Ferguson's antitrust immunity. *See Fabe*, 508 U.S. at 504 (holding the first clause of § 2(b) is not so "narrowly circumscribed" as is analysis under the second clause); *see also Rush Prudential*, 122 S. Ct. at 2163; *UNUM*, 526 U.S. at 373. Consequently, Kentucky's AWP laws need not satisfy all three factors in order for the result of the common-sense test to be confirmed. *Rush Prudential*, 122 S. Ct. at 2163; *UNUM*, 526 U.S. at 373. In fact, Kentucky's laws satisfy all three factors.

2. *Kentucky's AWP Laws Satisfy All Three McCarran-Ferguson Factors.*

The first McCarran-Ferguson factor asks whether the law at issue "targets practices or provisions that 'ha[ve] the effect of transferring or spreading a policyholder's risk.'" *Rush Prudential*, 122 S.Ct at 2163 (quoting *Pireno*, 458 U.S. at 129). AWP laws satisfy this factor in two respects. First, AWP statutes transfer some of the risk that an insured will have to pay higher out-of-pocket costs to use a health care provider of choice because the insured is not satisfied with the choices from the network. For example, under petitioners' HMO policy, an insured scheduling office visits with a physician outside of the HMO's provider network must pay a medical services copayment of $150 plus twenty percent of the total cost incurred per office visit. *See* J.A. 86a-88a. By contrast, if the insured visits a doctor within the provider network, he or she pays only a $10 co-payment per visit. *See id.* at 88a. By broadening the number of doctors in a provider network, AWP laws make it more likely that insureds will

pay only the standard co-payment for their office visits because they will able to select their preferred provider from within the network.[8]

Second, AWP laws may require policyholders or insureds to bear additional costs resulting from greater provider choice insofar as HMOs charge higher premiums or reduce coverage in response to AWP laws.[9] AWP laws also have the effect of spreading risk among policyholders as compared to policies that require only those insureds who go outside the network to bear a higher cost for doing so. *See Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500, 503 (4th Cir.) (by prohibiting "unreasonable restrictions [on] providers," AWP laws "spread[] the cost component of the policyholder's risk among all the insureds, instead of requiring the policyholder to shoulder all or part of this cost when seeking care or treatment from an excluded doctor or hospital of his or her choice"), *cert. denied*, 510 U.S. 1003-04 (1993). *Cf. Metro. Life*, 471 U.S. at 743 (holding that mandated-benefit law effectively forcing good-risk policyholders to bear part of the cost of mental-health insurance by becoming part of the risk pool "obviously regulates the spreading of risk"). Thus,

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[8] As the court below explained, while there is no guarantee that an insured's preferred provider will join a network,

> it does not...change the fact that the statutes open an otherwise closed door, insofar as the availability of health care providers is concerned. Some may choose to go through that door and join the group of providers while others may not, but this does not mean that removal of a restriction on availability of providers is not a benefit conferred on the insureds.

Pet. App. 31a.

[9] Petitioners argue that AWP laws necessarily "increase the cost of managed care." Pet. Br. 5 n.4. To the extent such cost increases occur, one possible response of insurers may be to pass them on directly in the form of higher premiums. *See* Note, *Health Care Law—HMO Regulation—Arkansas Requires HMOs to Accept Any Provider Willing to Join Their Networks*, 109 Harv. L. Rev. 2122, 2125 (1996).

AWP laws satisfy the first McCarran-Ferguson factor by spreading risk both vertically (between insurers and policyholders) and horizontally (among policyholders).

The relationship of AWP laws to risk is also apparent from the fact that HMOs were a low-cost response to traditional indemnification insurance in which insureds had freedom to choose providers. *Cf. Pegram*, 530 U.S. at 218 ("In a fee-for-service system, a physician's financial incentive is to provide more care, not less, so long as payment is forthcoming."). HMOs were purposefully designed to restrict choice and thereby save money, both for insurers and insureds, the latter through lower premiums. *Cf. id.* at 219 (HMOs implement numerous "cost-controlling measures [that] are commonly complemented by specific financial incentives to physicians, rewarding them for decreasing utilization of health-care services, and penalizing them for what may be found to be excessive treatment") (citations omitted). AWP laws, in turn, were a state regulatory response designed in part to provide insureds with more choices than HMOs would otherwise allow under their existing policies. *See* James W. Childs, Jr., Comment, *You May Be Willing, But Are You Able?: A Critical Analysis of "Any Willing Provider" Legislation*, 27 Cumb. L. Rev. 199, 217 (1996) (explaining that "public support for AWP legislation may more realistically represent the balance of cost and choice that the 'public' is seeking"). Thus, by restoring a measure of the choice provided by traditional fee-for-service insurance, AWP laws reallocate risk between insurer and insured.

Petitioners assert that AWP laws cannot satisfy the risk-spreading factor because "the 'risk' HMOs insure against is not the loss arising out of a desire to pay one provider rather than another for particular care, . . . [but] is the loss arising

from the need to pay for care at all."[10] Pet. Br. 23-24. The flaw in this position is that the risk of paying for the care required when an insurable event occurs varies with what the insurer agrees to underwrite as compensable treatment for the event. *See, e.g.*, *Stuart Circle*, 995 F.2d at 503 (noting that "[t]here are several components to the 'policyholder's risk'" and explaining how AWP laws relate to those components). In short, where an insurance contract limits the insured's choice of health care providers, AWP laws legislatively amend the terms of the insurance agreement between the insurer and insured, redistributing the original risk allocation by providing the insured with a broader range of provider choice. By changing the terms of the contract and redistributing risk, AWP laws satisfy the McCarran-Ferguson "risk-spreading" factor.

The second McCarran-Ferguson factor asks whether a law "targets practices or provisions . . . '[that are] an integral part of the policy relationship between the insurer and the insured.'" *Rush Prudential*, 122 S. Ct at 2163 (quoting *Pireno*, 458 U.S. at 129). This factor is easily satisfied by AWP laws. This conclusion holds true both for laws that require insurers to open their networks to a broad range of

[10] Petitioners also argue that the risk-spreading factor is not satisfied because "[t]here can be no genuine dispute that HMO provider contracts do not spread or underwrite risk." Pet. Br. 32. This argument focuses on the wrong contractual relationship. When applying the first McCarran-Ferguson factor, this Court focuses on whether the law at issue targets practices or provisions "transferring or spreading a *policyholder's* risk." *Rush Prudential*, 122 S. Ct. at 2163 (emphasis added) (quoting *Pireno*, 458 U.S. at 129). As discussed in greater detail below, *see* p. 25 *infra*, while AWP laws may *affect* the contract between an insurance company and doctors in its provider network, AWP laws principally target the contract between an insurer and the insured.

health care providers, as well as for those state laws applicable only to a limited group of providers, such as pharmacists.[11]

When, like the Kentucky statutes, AWP laws apply to all health care providers, it is apparent, as noted by the majority below, that "[t]he ability of an insured to select a physician of his or her choice to treat a medical condition covered by the insurance is an integral part of the policy relationship between the insurer and the insured." Pet. App. 35a. Petitioners argue that requiring open networks will make it only "marginally" more likely that a policyholder will be able to choose their preferred doctor. Pet. Br. 34. Not only is that assertion open to question, but as the court below noted, whatever its validity it "does not mean that removal of a restriction on availability of providers is not a benefit conferred on the insureds. It effectively changes the terms of the policy, admittedly not in terms of covered medical condition but in terms of covered treatment by health care providers." Pet. App. 31a-32a. Thus, an AWP provision provides insureds with larger provider networks that provide both enhanced choice and a greater likelihood that the insured's preferred provider will be in the network.

AWP laws also provide other important benefits to insureds. As a practical matter, larger networks make it more likely that an insured will know a relative, friend, or coworker who can recommend someone who is in the network. *See* Dianne McCarthy, Note, *Narrowing Provider Choice: Any Willing Provider Laws After* New York Blue Cross v. Travelers, 23 Am. J.L. & Med. 97, 109 (1997) (noting that individuals looking for network providers are more likely to rely on the advice of friends and coworkers rather than "choosing a name from a book or relying on a faceless MCO screener for a referral"). Similarly, if insureds do not like the

[11] As noted *infra* at pp. 27-28, the scope of coverage of AWP laws varies from state to state.

first health care provider that they choose, larger networks will make it easier for them to switch to another doctor. In short, even if insureds are ultimately unable to select their first-choice provider from within the network, a larger network does enhance their range of choice.

Petitioners assert that an enhancement of provider choice is not "'integral'—or even germane—to the *contract of insurance* between insurer and insured." Pet. Br. 34. They argue that because the Court in *Royal Drug* found that insureds were "'basically unconcerned'" with the pharmacy choice that resulted from an arrangement made by an insurer to control the cost of prescription drugs by creating a closed network, an insured's interest in the expansion of physician choice is not "integral" to the contractual relationship between the insurer and the insured. Pet. Br. 35 (quoting 440 U.S. at 214).

The flaw in the petitioners' argument is that *Royal Drug*, which involved McCarran-Ferguson's narrow antitrust immunity, is of limited relevance when a State is regulating insurance. *See Fabe*, 508 U.S. at 504-05. And even if insureds remain "basically unconcerned with arrangements made between [insurers] and participating pharmacies," *Royal Drug*, 440 U.S. at 214—a proposition open to serious question in 2002[12]—petitioners' argument is utterly unpersuasive when

[12] In the twenty-three years since *Royal Drug* was decided, changes in the pharmacy industry have led to instances of extreme customer dissatisfaction with some dominant pharmacy chains, making choice of pharmacy a matter of considerable "concern" to insureds. *See, e.g.*, Sarah Godfrey, *Crummy Variety Store: With 50 Outlets in the District, CVS has a near monopoly on drugs, cough syrup, hair spray—and customer dissatisfaction*, Washington City Paper, March 1-7, 2002 (describing customer dissatisfaction with dominant pharmacy chain in Washington, D.C.), *available at* http://www.washingtoncitypaper.com/archives/cover/2002/print_cover0301.html.

In addition to overall dissatisfaction, privacy concerns may cause a consumer to patronize one pharmacy over another. *See, e.g.*, Rea Blakey, *Pharmacies Jeopardizing Patient Privacy* (June 12, 2002) (discussing business practice of pharmacies selling private medical information to pharmaceutical companies and noting that "[p]atients who don't agree with their providers' practice . . . can try finding a new provider, or pay out of pocket"), *at* http://www.cnn.com/2002/HEALTH/06/12/pharmaceutical.privacy/index.html. Similarly, a desire to avoid drug complications may cause an insured to seek out certain pharmacies.

applied to the expanded physician choice effectuated by Kentucky's AWP law. *See* Br. *Am. Cur.* U.S. on Pet. 15 (policyholders "are likely to be very concerned with the range of providers available to them under [their health insurance] plan").

This Court has made clear that AWP laws require the insurer to alter the terms of the policy in a manner that is an integral part of the policy relationship, as a comparison of two of the Court's cases shows. In *Pireno*, the Court held that an insurer's unilateral use of a peer review committee to advise the insurer as to whether certain medical services were reasonable and necessary was not an integral part of the insurance relationship in part because "[t]he insurer's contract for advice from a third party was no concern of the insured, who was not bound by the peer review committee's recommendation any more, for that matter, than the insurer was." *Rush Prudential*, 122 S. Ct. at 2164 (citing *Pireno*, 458 U.S. at 132). In contrast, in *Rush Prudential* the Court held a state law that added an extra layer of review for an HMO's denial of coverage was integral to the insurer-insured relationship because the law provided "a legal right to the insured [that was] enforceable against the HMO." *Id.* Thus, while a unilaterally created review panel whose decisions are not binding "is a matter of indifference to the policyholder," *Pireno*, 458 U.S. at 132, the same cannot be said for state laws, such as Kentucky's AWP laws, that alter the terms of an HMO's insurance policy and vest legal rights in the

insured; such laws create a right that is integral to the policy relationship and is enforceable by the State's Insurance Commissioner.[13]

The Court's holding in *Royal Drug* is entirely consistent with this analysis. *Royal Drug* held that when an insured buys a policy that gives the insurer a contractual right to specify network pharmacies, the insured has no contractual right to select a different pharmacy. But *Royal Drug* is readily distinguishable from this case, in which the State has created a right to select a provider (or, alternatively, expands the network beyond the insurers' discretion). In this situation, the state-created right becomes an integral part of the insurance relationship. While for antitrust purposes the manner in which the insurer contracts with third parties to provide drug benefits may not be a part of the policy relationship, *see Royal Drug*, 440 U.S. at 216, when a state legislature passes legislation that requires the insurer to admit any willing provider to its pharmacy network, the State has clearly effectuated a change in coverage that is an integral part of the policy relationship.

The fatal flaw in petitioners' *Royal Drug* argument is that there is a fundamental difference between an insurance company entering into contracts that may raise antitrust concerns and seeking an exemption under the second clause of McCarran-Ferguson § 2(b), and a state insurance regulation that is saved from preemption by the first clause of § 2(b). *See Fabe*, 508 U.S. at 504. Thus preservation of Kentucky's AWP laws from preemption by ERISA is entirely consistent with the outcome of *Royal Drug* – both ultimately favor regulation of the insurance industry, by the States as a general matter and by the Federal Government as to antitrust. To conclude otherwise would lead to the anomalous result that

[13] *See* discussion *supra* at pp. 11-13 & n. 4 concerning state enforcement of AWP laws by insurance commissioners in Kentucky and other States.

the McCarran-Ferguson factors *exempt* the insurance industry from state regulation when "[t]here is no question that the *primary* purpose of the McCarran-Ferguson Act was to preserve state regulation of the activities of insurance companies." *Royal Drug*, 440 U.S. at 218 n.18.

Finally, for the same reasons that AWP laws regulate insurance as a matter of common sense, *see* pp. 8-14 *supra*, AWP statutes satisfy the third McCarran-Ferguson factor – whether the law "targets practices or provisions that . . . '[are] limited to entities within the insurance industry.'" *Rush Prudential*, 122 S. Ct at 2163 (quoting *Pireno*, 458 U.S. at 129); *see also UNUM*, 526 U.S. at 375.

Petitioners contend that this factor is not satisfied because AWP "laws regulate insurers *and providers*[] by barring the latter from entering into limited network contracts with the former." Pet. Br. 27. This argument ignores the plain meaning of the third McCarran-Ferguson factor, which is whether the law "*targets* practices or provisions . . . [that are] limited to entities within the insurance industry" *Rush Prudential*, 122 S. Ct. at 2163 (quoting *Pireno*, 458 U.S. at 129) (emphasis added); it does not require a hermetic seal that would prevent the law from having an incidental effect on anyone else. AWP laws are obviously targeted at insurance industry practices and the provisions of health insurance policies. While these laws may have *consequences* that affect third-party providers, they are not *targeted* at those providers. *Cf. Fabe*, 508 U.S. at 501 (noting in the context of McCarran-Ferguson's saving clause that laws "'aimed at protecting or regulating this relationship [between insurer and insured], directly or indirectly, are laws regulating the "business of insurance"' within the meaning of the phrase"). (quoting *SEC v. National Securities*, 393 U.S. at 460). Therefore, like the first two McCarran-Ferguson factors, the third factor is also satisfied by Kentucky's AWP laws.

C. ERISA Preemption of Kentucky's AWP Laws Would Deprive States Of The Ability To Regulate HMO Insurance Practices And Would Create A Regulatory Void.

The substantive policy implications of the various AWP laws enacted nationwide militate strongly against a finding of ERISA preemption of Kentucky's AWP laws. Reversal of the judgment below would create a regulatory void in areas where Congress has consistently deferred to state regulation. Petitioners' analysis of the preemptive effect of ERISA would be inconsistent with the presumption that in the absence of federal regulation, federal statutes should not be construed to create a regulatory void by preempting state regulation. *See Pacific Gas & Elec. Co. v. State Energy Res. Conserv. & Dev. Comm'n*, 461 U.S. 190, 207-08 (1983) (finding that States must have regulatory authority over the economic aspects of nuclear power where Congress had not expressly given such authority to the federal government because "[i]t is almost inconceivable that Congress would have left a regulatory vacuum"). For this and other reasons, the Court has instructed that the scope of ERISA preemption must be determined against the background "'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.'" *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995) (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

That point is emphasized by the implications of preemption of AWP laws. Kentucky's AWP laws reflect the public policy concerns that have been raised in numerous state legislatures as a reaction to HMOs' use of limited-provider networks as a means of controlling costs.[14] Indeed, "HMOs

[14] Indeed, petitioners and their *amici* contend that AWP laws are too costly to be justified. Pet. Br. 4-5. This is an argument that has no logical place in this Court's determination as to whether ERISA's saving clause applies. Cost considerations are matter properly considered by the States and by Congress, which remains free to intercede in this area of public policy if it deems intervention appropriate.

became popular because fee-for-service physicians were thought to be providing unnecessary or useless services; today, many doctors and other observers argue that HMOs often ignore the individual needs of a patient in order to improve the HMOs' bottom lines." *Pegram*, 530 U.S. at 220.

Kentucky's AWP laws are what this Court in a related context has called "only one variety of a matrix" of state insurance statutes "that regulate the substantive content of health-insurance policies to further state health policy." *Metro. Life*, 471 U.S. at 729. Indeed, the States continue to develop and experiment with AWP provisions, as "approximately twenty-five States have enacted some form of AWP law." Br. *Am. Cur.* U.S. on Pet. 19. Several AWP laws follow Kentucky's model and prohibit an insurer from discriminating against any health care provider willing to abide by the insurer's terms.[15] Other States' AWP laws require insurers to admit pharmacists or pharmacies willing to meet an insurer's conditions.[16] Other States have likewise

[15] *See, e.g.*, Ark. Code Ann. § 23-99-204(a)(3) (Michie 1999); Ga. Code Ann. § 33-20-16 (2000); Idaho Code § 41-3927(1) (Michie 1998); 215 Ill. Comp. Stat. 5/370h (2000); Ind. Code Ann. § 27-8-11-3(c) (Michie 1999); Wyo. Stat. Ann. § 26-22-503 (Michie 2001).

[16] *See, e.g.*, Ala. Code § 27-45-3 (Supp. 2002); Conn. Gen. Stat. Ann. § 38a-471(f) (2000); Del Code Ann. tit. 18, § 7303 (1999); 215 Ill. Comp. Stat. 134/72(a) (2000); La. Rev. Stat. Ann. § 22:1214(15)(a) (West 1995); Mass. Gen. Laws Ann. ch. 176D, § 3B (West 1998); Miss. Code Ann. § 83-9-6 (1999); N.H. Rev. Stat. Ann. § 420-B:12(V.) (1998); N.J. Stat. Ann. § 26:2J-4.7 (West 1996); N.C. Gen. Stat. § 58-51-37 (2001); N.D. Cent. Code § 26.1-36-12.2 (1995); S.C. Code Ann. § 38-71-147 (Law. Co-op. 2002); S.D. Codified Laws § 58-18-37 (Michie 2000); Tenn. Code Ann. § 56-7-2359 (2000); Tex. Ins. Code Ann. § 21.52B (Vernon Supp. 2002).

elected to apply AWP laws solely to certain types of health care providers. *See, e.g.*, Miss. Code Ann. § 83-41-203 (1999) (optometrists); Okla. Stat. tit. 36, § 3634 (1999) (podiatrists, psychologists, and clinical social workers). Thus, a wide variety of state AWP laws applicable to HMOs could be called into question if the judgment below is reversed.

Moreover, ERISA does not substantively regulate HMOs' medical-treatment decisions. *See, e.g.*, *Travelers*, 514 U.S. at 651 (ERISA "does not go about protecting plan participants and their beneficiaries by requiring employers to provide any given set of minimum benefits"); *Metro. Life*, 471 U.S. at 732 ("ERISA . . . contains almost no federal regulation of the terms of benefit plans."). Accordingly, if state insurance regulation is preempted, HMOs will not be subject to any corresponding federal regulation. ERISA plan participants and their beneficiaries, whom Congress sought to protect by enacting ERISA and its saving clause preserving state insurance regulation, will be deprived of protection unless the States' ability to regulate HMOs remains intact.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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